Payment & Reimbursement At A Glance

A Guide to Receiving Financial Assistance

South Carolina
State Office of Victim Assistance **SOVA**

SOVA
SOUTH CAROLINA
State Office of Victim Assistance
Rooted in *justice*
Guided by *law*
Propelled by *humanity*

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Phone 803.734.1900 | Victims Only Please 1.800.220.5370 | www.sova.sc.gov

A Guide to Receiving Financial Assistance from SOVA

PART ONE:
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Disclaimers

This PDF has been designed to help you navigate your way through our Payment and Reimbursement process. In preparation of this material, every effort has been made to offer the most current, correct, and clearly expressed information possible. However, this information is for general purposes only. While SOVA makes every effort to provide accurate and updated material for you; periodically, data may change prior to any updates and revisions. Therefore, you are encouraged to contact our office if you have any questions.

This material is not provided as a guarantee for payment or pre-approval for services. SOVA is providing this information in an effort to decrease the turn-a-round time for processing claims. All claims or applications for assistance must meet the eligibility criteria prior to consideration with crime related compensable expenses. Victims/claimants are encouraged to provide this agency with the appropriate documentation for reimbursement and payment consideration.

Forms:
Any information submitted on the forms is fictitious and intended for sample purposes only. Actual forms will reflect real data entered by providers. This material also includes forms from organizations other than SOVA and has been provided for sample purposes only.

Victim's privacy:
To protect victim/claimant's privacy, SOVA will not provide information to family or friends without prior authorization from the victims/claimants in writing.

Pre-existing conditions:
If you have a pre-existing medical/dental condition (a condition that existed prior to the crime), you could be required to provide the agency with a Certificate of Clinical/Dental Necessity from your treating physician/clinician/dentist certifying that your treatment is directly related to the crime on which the claim is based and that the expenses incurred as a result of your treatment are crime related.

Victims' Responsibilities

Important Information for Advocates, Providers and Victims

Payer of Last Resort:
SOVA is an eligibility program. All submitted compensable expenses will be offset by other available sources before reimbursements/payments are considered. Victims will be required to file all compensable expenses with his/her private or public health insurance company/carrier first; this includes Medicaid and Medicare. Victims' compensable expenses are also offset by restitution, subrogation or civil settlements. Because SOVA is not a guarantor for crime victims compensable expenses, providers are encouraged to mail all bills to victims and forward UBs/HCFAs etc. to SOVA.

Change of address for victims/claimants:
To ensure timely payments/reimbursements or to avoid interruptions of lost wages, the victims/claimants will be required to provide SOVA with change of address and telephone number

Victim Compensation Code of Laws

Visit: **http://www.scstatehouse.net/code/t16c003.htm**
Title 16, Chapter 3, Section 16-3-1110 * 16-3-1420
for a complete listing of the laws.

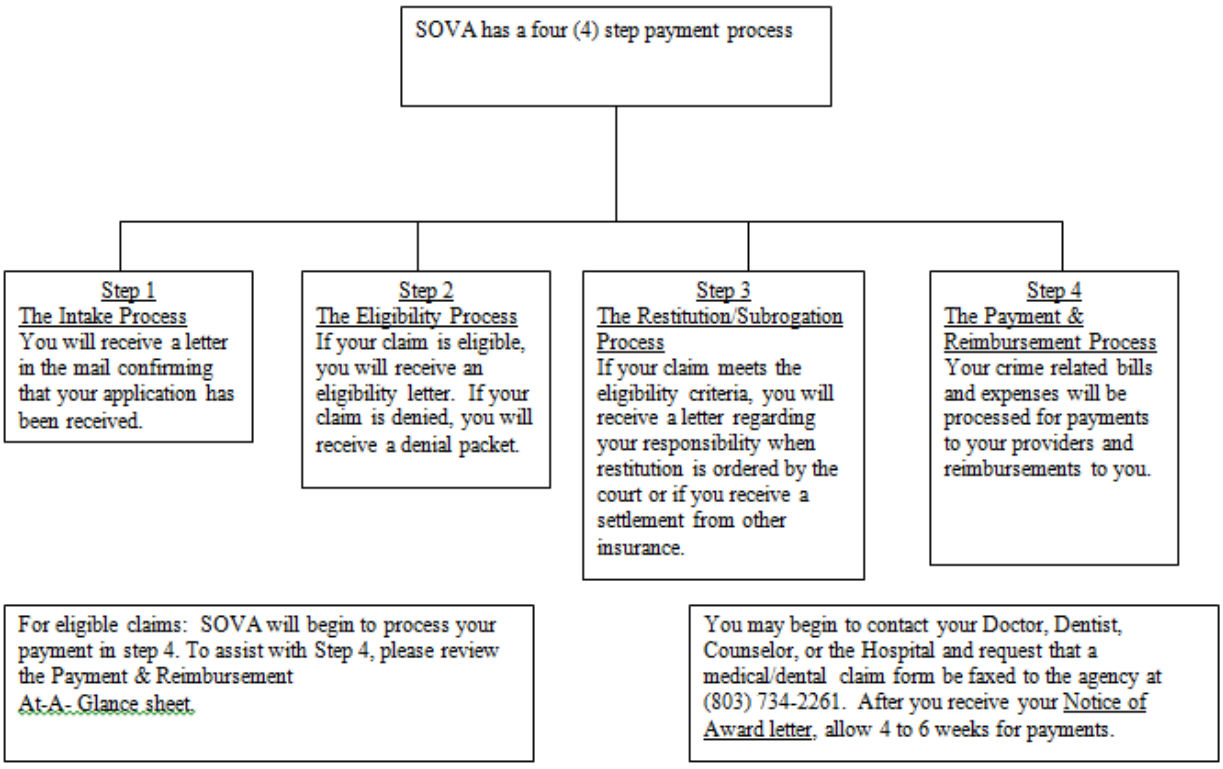
Collection Activity:
Section 16 3 1360: Collection activities prohibited
When a person files a claim pursuant to this article, a health care provider that has received written notice of a pending claim is prohibited from all debt collection activities relating to medical and psychological treatment received by the person in connection with the claim until an award is made on the claim or the claim is determined to be non-compensable and is denied, or ninety days have passed after the health care provider first received notice of a pending claim.

$100.00 Threshold:
Section 16-3-1180(D) An award may be made only if and to the extent that the amount of compensable loss exceeds one hundred dollars; however, this limitation may be waived in the interest of justice and must be waived upon a showing that the claimant is at least sixty-five years old.

Claims inactive for more than 18 months:
Section 16-3-1180(E) A previously decided award may be reopened for the purpose of increasing the compensation previously awarded. The State Office of Victim Assistance shall send immediately to the claimant a copy of the notice changing the award. This review may not be made after eighteen months from the date of the last payment of compensation pursuant to an award under this article unless the director determines there is a need to reopen the case as specified in Section 16-3-1120(4).

PART ONE:

COMPENSATION PROGRAM



Crime Related Expenses (For Medical/Dental/Eyeglasses)

Medical

Victims must submit the following forms for his/her crime related medical expenses to be considered for payments/reimbursements:

One of the following forms will be required for all separate crime related dates of service.
The victim will have to contact his/her provider (provider can mail or fax the medical claim forms).

- UB-04 Medical Claim Form
- UB-92 Medical Claim Form
- Health Insurance Medical Claim Form (CMS-1500) (HCFA-1500)
- Itemized bill of Charges from your medical provider
- Health Insurance information Explanation of Benefits (EOB)

When the victim has health insurance coverage, he/she will be required to provide information.

- Explanation of Benefits from the Health Insurance Company or provider (EOB)
- Pursuant to public and private health insurance guidelines regarding timely filing and pre-authorization, victims are required to provide providers with health insurance information.

Dental

Victims must submit the following forms for his/her crime related dental expenses to be considered for payment/reimbursements: **(Look for the Dental Fee Schedule in Section Three.)**

One of the following forms will be required for all separate crime related dates of service.
The victim will have to contact his/her provider (provider can mail or fax the dental claim forms).

- Itemized bill of Charges from your medical provider
- ADA Dental Claim Form (w/ treatment plan)
- Health Insurance information Explanation of Benefits (EOB)

When the victim has dental insurance coverage, he/she will be required to provide information.

- Explanation of Benefits from the Health Insurance Company or provider (EOB)
- Pursuant to public and private health insurance guidelines regarding timely filing and pre-authorization, victims are required to provide providers with health insurance information.

Eyeglasses

Replacement or purchase of eyeglasses is a compensable expense when:

- It is found that the victim's glasses were broken or damaged during the incident;
- The damaged/broken glasses were reported to law enforcement;
- The information is in a police report or supplemental report;
- A detailed bill from your chosen vision center is submitted
- The injury was reported to law enforcement;
- The victim's vision is impaired as a direct result of the crime;
- Medical documentation supports that the glasses are medically necessary;
- A detailed bill from your chosen vision center is submitted.

Note: SOVA will pay a maximum of $125.00 for eyeglass frames. Lenses are covered in full according to the prescription when it is found to be medically necessary. Warranties are not a covered expense.

Crime Related Funeral Expenses

(Look for the Funeral Bill Case Status Form and Funeral Memorandum of Understanding Form in Section #3.)

Claimants must submit the following forms/documents for the crime related funeral expenses to be considered for payments/reimbursements:

- Death Certificate
- Itemized bill/contract (The bill must include the service provider's name and remit address.)

The person who is responsible for the funeral expenses incurred may file for reimbursements relating to the cost of the funeral. The responsible party is the person(s) who signed the contract or who paid the funeral bill.

Compensable Medical Expenses:

- If the deceased victim was an adult, the victim's spouse may file for any compensable medical expenses that he/she may have incurred.
- If the deceased victim was a minor child, the parent may file for any compensable medical expenses he/she may have incurred.

Crime Related Counseling Expenses

- SOVA's mental health policy provides an incremental approach to outpatient mental health sessions' limitation. This approach was implemented on July 1, 2012 and applies to all eligible and active claims.
- The Provider must be a licensed mental health professional, who has received specific training in evidence based treatment that have been shown to be effective in meeting the need of crime victims.

For consideration with approved limits, providers will be required to provide the following:

- SOVA Mental Health Counselor's Report
- SOVA Additional counseling Sessions Request form for additional sessions
- Itemized bill of Charges or,
- Health Insurance Medical Claim Form (CMS/HCFA-1500)
- Explanation of Benefits (EOB) for each date of service

Payer of Last Resort:
The State Office of Victim Assistance is the payer of last resort. If the victim has insurance, and the victim elects not to use his/her insurance for treatment, SOVA will not cover the cost. It is the provider's responsibility to ensure that other avenues of payments are explored and used.

Timely Filing:
SOVA highly recommends that claims be filed as soon as possible after services have been rendered to ensure prompt payments. However, SOVA requires providers to submit invoices and medical claim forms within 12 months from the date of service. Request for payment submitted after 12 months from the date of service will not be considered. For new victim compensation claims/applications: Claims (invoices/medical claim forms) for services provided must be submitted within 12 months after the date of eligibility.

Crime Related "Out of pocket expenses" for

Prescription Drugs

Victims must submit the following information for his/her crime related "out of pocket expenses" to be considered for reimbursement:

One of the following will be required (Some victims will have to provide additional information from his/her treating physician)

- Copy of receipt from the pharmacy (*receipt must have* - patient's name, date, total charge, name of medication, RX (prescription) number, name of the pharmacy & name of the doctor), or
- Print out of 'patient history' from the pharmacy.

Mileage for Transportation To and From Medical/Dental/Counseling Appointments

Victims must submit the following information to be considered for reimbursement for his/her expenses relating to transportation to and from appointments:

MILEAGE: What will be required?

- A written request from the victim/claimant
- List of appointments for which you are requesting consideration for mileage
- Medical claim forms/itemized bills for each appointment

IMPORTANT NOTE: (Mileage is considered for SOVA's compensable related expenses ONLY)

- Medical/Dental/Counseling claim forms are used to confirm appointments.
- The distance between the victim/claimant's home and the medical/dental/counseling facility must be 5 miles or more (one way).
- The request must be submitted in writing (the request must include the date of the visit, service type and location)

The following are non-covered expenses:

- Mileage for court appearances
- Mileage for meetings with law enforcement
- Mileage for meetings with Solicitors
- Mileage for Medicaid and Medicare recipients

Crime Related

Lost Wages

CRITERIA: (all four criteria must be met)

1) Employed: The victim must have been employed at the time of the crime;
2) Missed time from work: The victim must have missed two (2) consecutive weeks from work as a direct result of the crime;
3) Reportable income: Reimbursement is based on reportable income; and
4) Disabled: The victim must be under the care of a treating physician.

LOST WAGES: (The victim must have been employed at the time of the crime and missed two consecutive weeks from work as prescribed by the treating physician.)

Victims must submit the following information for his/her crime related lost wages to be considered for reimbursement:

- SOVA Employer's Report
- SOVA Physician's Disability Report
- Copy of your last two pay stubs prior to the incident
- Other documentation may be required for individuals who are self-employed (See the 'Self Employed' section for additional information)

Self-Employed

This section applies to you:

- If you were self-employed at the time of the crime
- If you received your earnings in cash, personal checks or money order
- If you received your earnings in tips
- If you report your income to the IRS

Victims must submit the following information for his/her crime related lost wages to be considered for reimbursement: To establish disability, employment and reportable income; three (3) supportive documentations will be required. The criteria for lost wages are listed under Crime Related Lost Wages.

1) Disability:
- SOVA Physician's Disability Report will be required to establish disability and length of disability.

2) Employment:
- SOVA Self-Employment Verification of Lost Wages Form
- A copy of your Business License (if applicable), or
- Documentation showing you were receiving income, from the business, at the time of the crime

3) Reportable Income: (lost wage benefits are calculated using information for the year of the crime)
- Your Tax Return Transcript from the IRS is required (must submit the last two years prior to the crime)

Self-Employed cont.

To have your tax return transcript mailed to you:

You can order your tax return transcript(s) using the IRS Order a Transcript self-service transcript order line at:

- 1.800.908.9946: Then,
- Select option 1 for English, then
- Enter your SS#, then
- Select 1 to confirm your SS#, then
- Enter your house or apartment number,
- You will be provided with instructions, then
- Select option 2 to order your transcript, then
- Enter the year for the tax return you are ordering (year of the crime) i.e. 2013; 2012; 2011, then
- Select option 1 to confirm the year for the tax return that you are ordering,
- After the prompt, if your information is correct, select option 1, finally
- Select option 3 to complete your order

There are no fees for the tax return transcript. You can expect to receive your transcript within 5 to 10 days from your order date.

To have your tax return transcript faxed to you:

You can order a faxed copy of your tax return transcript(s) by calling the IRS at 1-800-829-1040. **You must be near a fax machine at the time of the call.** Instructions are below:

- 1.800.829.1040 - IRS general information line
- Select option 1 for English
- Press zero or (wait to go through the prompts to speak with an operator)
- Ask the operator to transfer you to the Advance Accounts Department. (The hold time is typically 15 minutes)
- When the representative from the Advance Accounts Dept. comes on the line, you may request a faxed copy of your tax transcript. Be prepared to provide your social security number and a fax number.

There are no fees for the tax return transcript. You can expect to receive your transcript within 5 to 10 days from your order date.

NOTE: Payment for lost wage benefits are limited to one half of the overall compensation award amount and a 12-month disability period.

PART TWO:

SAP/CAP PROGRAM

Sexual Assault Protocol (SAP)
Child Physical Assault Protocol (CAP)

Eligibility Criteria

SAP/CAP PROGRAM: Pursuant to SECTION 16-3-1350, SOVA is the primary payer and victims/claimants are not to be billed

- A crime occurred in South Carolina
- Claim must be filed within 180 days from the date of service

Sexual Assault (Acute) Protocols: (Victims 18 and older)

- SLED approved protocol must be followed

Anonymous Reporting: Sexual Assault (Acute) Protocols (Victims 18 and older)

SLED approved protocol must be followed: when providing law enforcement information –write in "Anonymous" instead of the name of the law enforcement agency: To establish that the crime happened in SC or incident jurisdiction, provide the county and state.

Sexual Assault (Chronic) Protocols: (Victims 17 and younger or vulnerable adults)

- South Carolina Children's Advocacy Medical Response System Child Maltreatment Protocol must be followed …… visit http://www.sccamrs.org for more information
- The crime was reported to law enforcement

Forensic Interviews: (Victims 17 and younger or vulnerable adults)

- The forensic interview was performed using the standards defined by SOVA
- The crime was reported to law enforcement

PAYMENT STIPULATION: For reimbursement of Sexual Assault or Physical Abuse (Chronic) Protocols and Forensic exams or Forensic interviews, a law enforcement agency is required to be the initiating/requesting party. SOVA will only pay for allowable charges incurred, in gathering evidence from a victim 17 and under or a vulnerable adult, when done at the request of law enforcement.

SECTION 16-3-1350. Medicolegal examinations for victims of criminal sexual conduct or child sex abuse. [SC ST SEC 16-3-1350]

(A) The State must ensure that a victim of criminal sexual conduct in any degree, criminal sexual conduct with a minor in any degree, or child sexual abuse must not bear the cost of his or her routine medicolegal exam following the assault.

(B) These exams must be standardized relevant to medical treatment and to gathering evidence from the body of the victim and must be based on and meet minimum standards for rape exam protocol as developed by the South Carolina Law Enforcement Division, the South Carolina Hospital Association, and the Governor's Office Division of Victim Assistance with production costs to be paid from funds appropriated for the Victim's Compensation Fund. These exams must include treatment for sexually transmitted diseases, and must include medication for pregnancy prevention if indicated and if desired. The South Carolina Law Enforcement Division must distribute these exam kits to any licensed health care facility providing sexual assault exams. When dealing with a victim of criminal sexual assault, the law enforcement agency immediately must transport the victim to the nearest licensed health care facility which performs sexual assault exams. A health care facility providing sexual assault exams must use the standardized protocol described in this subsection.

(C) A licensed health care facility, upon completion of a routine sexual assault exam as described in subsection (B) performed on a victim of criminal sexual conduct in any degree, criminal sexual conduct with a minor in any degree, or child sexual abuse, may file a claim for reimbursement directly to the South Carolina Crime Victim's Compensation Fund if the offense occurred in South Carolina. The South Carolina Crime Victim's Compensation Fund must develop procedures for health care facilities to follow when filing a claim with respect to the privacy of the victim. Health care facility personnel must obtain information necessary for the claim at the time of the exam, if possible. The South Carolina Crime Victim's Compensation Fund must reimburse eligible health care facilities directly.

(D) The State Office of Victim Assistance must utilize existing funds appropriated from the general fund for the purpose of compensating licensed health care facilities for the cost of routine medical exams for sexual assault victims as described above. When the director determines that projected reimbursements in a fiscal year provided in this section exceed funds appropriated for payment of these reimbursements, he must direct the payment of the additional services from the Victim's Compensation Fund. For the purpose of this particular exam, the one hundred dollar deductible is waived for award eligibility under the fund. The South Carolina Victim's Compensation Fund must develop appropriate guidelines and procedures and distribute them to law enforcement agencies and appropriate health care facilities.

Billing Fact Sheet

Sexual Assault Forensic Medical Examination – 18 and older

Pursuant to SC Code Section 16-3-1350, which follows the guidance of the federal Violence Against Women Act statute, victims of assault in the State of South Carolina may request, at no cost to them, a forensic examination for sexual assault, regardless of their involvement with law enforcement. Health Care Providers will bill SOVA directly for individual charges for lab work, emergency room fee, physician's fee, etc. **Neither the victim nor their insurance, including Medicaid and Medicare, may be billed for the medicolegal examination.** Any fees beyond the actual collection of any evidence during a forensic examination will be the responsibility of the victim. Should law enforcement be involved, the option of SOVA victim compensation reimbursement becomes available.

Payment for a routine medicolegal examination of any alleged victim of assault in any degree is dependent upon the following criteria/conditions:

- The assault must have occurred in South Carolina
- SLED approved Sexual Assault Protocol must be followed
- SOVA Sexual Assault Protocol (SAP) Billing Statement must be submitted
- SOVA Medical Examination Release Form must be submitted: NOTE: **For Anonymous Reporting: when providing law enforcement information, write in 'ANONYMOUS' instead of the name of law enforcement agency. To establish that the crime/incident occurred in SC, the incident location (county and state) will be required.**

The medical examination release form and the SOVA billing statement found in the evidence collection kit must be completed and submitted to the State Office of Victim Assistance providing the following:

- Name, address and signature of victim
- Name and address of the health care facility
- When the incident was reported to law enforcement, the agency's name is required
- Incident location (county and state)

No payment will be made unless forms are completed and submitted with correct documentation within 180 days from the date of the exam.

This Program is not permitted to pay for additional procedures such as:

- Surgery, hospital admission, follow-up counseling, x-rays, follow-up examinations, treatment, blood work, alcohol or drug screens, or testing, stat charges, etc.
  [Victims of assault who incur charges not covered under the Sexual Assault Protocol Program may submit a Victim Compensation application for payment consideration to the Victims' Compensation Fund.]

The Protocol Program makes payments to health care providers on a monthly basis. When multiple claims are submitted from a single provider for payment, one check is issued and sent with a list showing victims covered by the payment.

If you need additional information you may contact us by calling 803.734.1900.

Fact Sheet

Forensic Interviews

The State Office of Victim Assistance (SOVA) is authorized by state law (SC CODE SEC 16-3-1350) to pay for allowable charges incurred in gathering evidence from a victim at law enforcement's request. The forensic interviewer must be a master's level licensed mental health professional and have participated in at least one forty-hour specialized forensic interviewer training provided through the American Prosecutor's Research Institute (APRI) Finding Words, the National Children's Advocacy Center (NCAC), or the American Professional Society on the Abuse of Children (APSAC). If not licensed, the forensic interviewer must be supervised by a licensed mental health professional, i.e. LMSW, LISW, LMFT, or LPC. Anyone supervising an unlicensed interviewer must provide a copy of their license. The unlicensed interviewer must be working towards a license. Once licensed the interviewer must provide a copy of their license.

To receive reimbursement for performing a forensic interview, the interviews must be conducted at a facility that follows the multi-disciplinary model; a billing invoice for services rendered as well as a summary of the findings must be submitted and signed by the service provider. Providers must have previously been approved by SOVA. Victims or their insurance must not be billed for these services.

In addition, a release form must be completed and submitted along with the billing invoice and summary of findings. This release must include:

1. Victim's name, address and signature of the victim/guardian,
2. Name, credentials and signature of the forensic interviewer,
3. Name and address of the provider,
4. Location of crime and name of the law enforcement agency that took the report,
5. Name of the investigating/reporting officer (and signature, if available).

Payment for a forensic interview of a child alleged to be the victim of physical or sexual assault is contingent upon the following conditions:

1. The crime must have occurred in South Carolina.
2. The victim or guardian must file an incident report with law enforcement.
3. The forensic interview must be ordered by law enforcement.
4. The forensic interview must be performed using the standards defined by SOVA.

A law enforcement incident report that names each child as a victim is required along with the billing information.

The program cannot pay for additional procedures such as psychological testing/evaluation or mental health treatment. Victims who incur other crime related medical or mental health bills may submit a separate Crime Victim's Compensation application to SOVA. The application will be reviewed for eligibility for certain benefits including mental health counseling. Also, a victim must file with his or her health insurance first for other incurred expenses. SOVA will consider balances due for treatment after payment by individual insurance.

PART THREE:

PAYMENTS & REIMBURSEMENTS "AT A GLANCE"

<u>Who may file</u> a "Crime Victim's Compensation Application" with SOVA?

<u>The Direct Victim:</u> The victim who sustained the injury or the victim who died as a direct result of the crime related injury sustained.

<u>The Indirect Victim</u>: Crime Type Specific

- **The Direct Victims' Spouse:** Consideration for Counseling Expenses
- **The Direct Victims' Children:** Consideration for Counseling Expenses
- **The Direct Victims' Parents:** Consideration for Counseling Expenses
- **The Direct Victims' Siblings:** Consideration for Counseling Expenses

<u>An application must be submitted for each person filing for compensation.</u>

A claim/application must be submitted for the direct victim first before consideration will be given to the indirect victim's claim/application.

Benefits for the indirect victim (spouses, children, parents, and siblings) are contingent upon the eligibility status of the direct victim's claim: If the direct victim's claim is eligible, the indirect victim's claim could be deemed eligible. If the direct victim's claim is ineligible, the indirect victim's claim could be deemed ineligible.

Compensation & Sexual Assault Programs at a Glance...

Compensation Program:
An Assistance Program Payer of Last Resort
SECTION 16-3-1180 & 16-3-1360

Sexual Assault Program:
Evidence Collection:
SECTION 16-3-1350

Medical/Dental/Optical Expenses
*Must provide: UB04/UB92/CMS 1500 medical claim form/itemized bill or ADA dental claim form along with EOB for each date of service

Sexual Assault Acute Protocol
*Evidence collected within 120 hours of the assault

Funeral Expenses
*$4,000 maximum allowed
Taken from the total award

Anonymous Reporting
Sexual Assault Acute Protocol
*Evidence collected within 120 hours of the assault -for victims 18 and older

Counseling
*20 sessions/180 days
*SOVA's mental health policy provides an incremental approach

Sexual Assault Chronic Protocol
*Evidence collected after 72 hours of the assault (www.sccamrs.org)

Prescription Drugs
*Must submit a copy of the paid bill from the pharmacy

Forensic Interviews
*Interview ordered by Law Enforcement
$175.00 one-time fee

Mileage
*Medical/Counseling/Dental Appointments only Compensable bills are used to confirm compensation

For all medical treatment as a result of physical injuries sustained during the assault, and for follow-up appointments, A victim compensation application will be required

Lost Wages
*Must have missed 2 consecutive weeks from work as prescribed by the Treating Physician:
NOTE: SOVA is the payer of last resort for Lost Wages

Compensation Program
All reimbursements are subtracted from the $15,000 maximum award amount.

Payment & Reimbursement At A Glance

IF you are requesting assistance with:	THEN you will need to provide:
Crime Related Medical/Dental/Optical Expenses For payments to the providers or reimbursements to victims, one or more of the following will be required for all separate crime related dates of service. The State Office of Victim Assistance is the payer of last resort. If the victim has insurance, and the victim elects not to use his/her insurance for treatment, SOVA will not cover the cost. It is the provider's responsibility to ensure that other avenues of payments are explored and used. ***NOTE: SOVA pays after health and dental insurance***	• UB-04 Medical Claim Form (from your provider) • UB-92 Medical Claim Form (from your provider) • Health Insurance Medical Claim form (CMS-1500) (HCFA-1500) (from your provider) • Itemized bill of charges from medical provider • ADA Dental Claim Form (w/treatment plan) (certificate of dental necessity might be required) • Itemized bill from vision center for eyeglasses • EOB (Explanation of Benefit from Health/Dental insurance company)(Health/Dental/Medicaid must be filed first if a victim has private or public insurance) When the victim has Health/Dental/Medicaid Insurance coverage, he/she will have to provide information for all crime related dates of service.
Crime Related Counseling Expenses SOVA provides reimbursement for trauma (generally considered as a medical expense) only when such service is rendered by a professional who is licensed in a specialty which includes mental health counseling; this includes LMSW (when not practicing independently) LPC, LMFT, LCSW, LISW, Psychiatrist, Psychologist, and MD. **NOTE:** SOVA's mental health policy provides an incremental approach to outpatient mental health sessions. **NOTE:** The provider must have received specific training in evidence-based treatment that has been shown to be effective in meeting the needs of crime victims. ***NOTE: SOVA pays after health insurance.***	• SOVA Mental Health Counselor's Report • SOVA Additional Counseling Request Form • Itemized Statement of Charges w/CPT codes, or • Health Insurance Claim Form (CMS/HCFA-1500), (Providers can fax a copy to SOVA) • Explanation of Benefit (EOB) from the health insurance company **NOTE:** Insurance must be filed first if a victim has private or public insurance.
Crime Related Expenses for Medication For reimbursements to victims, one or more of the following will be required: **(Some victims will have to provide additional information from his/her treating physician if the medication appears to be for a pre-existing condition or non-crime related condition.)** ***NOTE: SOVA pays after health insurance.***	• Copy of receipt from the pharmacy (*receipt must have* - patient's name, date, total charge, name of medication, RX number, name of the pharmacy and name of the doctor) or • Print out of 'patient history' from the pharmacy
Crime Related Funeral Expenses The person who is responsible for the funeral expenses incurred may file for reimbursement relating to the cost of the funeral. That will be the person(s) who signed the contract or who paid the funeral bill.	• Death Certificate • Itemized bill/contract (* bill must include service provider's name and remit address)

Payment & Reimbursement At A Glance (continued)

IF you are requesting assistance with:	THEN you will need to provide:
Crime Related Lost Wages The following 4 (four) criteria must be met: 1. **Employment:** The victim must have been employed at the time of the crime, 2. **Missed time from work:** The victim must have missed two (2) consecutive weeks (14 days) from work as a direct result of the crime, 3. **Reportable income:** Reimbursement is based on reportable income, and 4. **Disabled:** The victim must be under the care of a treating physician.	The following documents must be submitted • SOVA Employer's Report • SOVA Physician's Disability Report • Copy of your last two pay stubs (prior to the crime date). ***NOTE: Because SOVA is a payer of last resort, all sources such as annual or sick leave, long/short term disability, SSA/SSI must be exhausted before SOVA will consider lost wage benefits.***
Crime Related Lost Wages (You were **self employed** at the time of the crime) 1. **Employment:** The victim must have been employed at the time of the crime, 2. **Missed time from work:** The victim must have missed two (2) consecutive weeks (14 days) from work as a direct result of the crime, 3. **Reportable income:** Reimbursement is based on reportable income, and 4. **Disabled:** The victim must be under the care of a treating Physician. ***NOTE: Because SOVA is a payer of last resort, all sources such as annual or sick leave, long/short term disability, SSA/SSI must be exhausted before SOVA will consider lost wage benefits.*** ***NOTE: Payment for lost wage benefits are limited to one half of the overall compensation award amount and a 12 month disability period.***	1) **Disability:** • SOVA Physician's Disability Report (will be required to establish disability and length of disability) 2) **Employment:** • SOVA Self-Employment Verification of Lost Wages form. • A copy of your Business License (if applicable), or • Documentation showing you were receiving income, from the business, at the time of the crime. 3) **Reportable Income:** (lost wages are calculated using information for the year of the crime) • Tax Return Transcript from the IRS (The last two years prior to the crime is required.)
Important Information	**Unprocessable Forms**
The following are forms/documents that are **UNPROCESSABLE** and **cannot** be accepted.	• Final Notice • Statements • Bills that are not itemized • Incomplete bills (missing information) • Cash register receipt from pharmacy • Incomplete receipt from pharmacy • Collection notices
Important Information	**Non-covered Expenses**
The following is a list of some non-covered expenses	• Treatment not directly related to the crime on which the claim is based • Over-the-counter items not prescribed by a treating physician • Mileage for court appearances • Hotel accommodations • Public transportation • Food items • Household items • Household utilities

Sexual Assault Program
Sexual Assault Forensic Medical Evidence Collection Examination
(Payment Procedure 'At A Glance')

IF you are requesting payments for:	THEN you will need to provide:
Sexual Assault Forensic Medical Examination **Sexual Assault (Acute) Protocol: Anonymous Reporting Protocol:** **Criteria for payments:** • The assault occurred in South Carolina • SLED approved protocol followed • The Claim was filed with SOVA within 180 days from the date of service Pursuant to South Carolina law which follows the guidance of the federal Violence Against Women Act statute, victims of assault in the State of South Carolina may request, at no cost to them, a forensic examination for sexual assault, regardless of their involvement with law enforcement. SOVA is the sole reimbursement provider for forensic examinations in South Carolina. Health Care Providers will bill SOVA directly for individual charges for lab work, emergency room fee, physician's fee, etc. Any fees beyond the actual collection of any evidence during a forensic examination will be the responsibility of the victim. Should law enforcement be involved, the option of SOVA victim compensation reimbursement becomes available.	**Sexual Assault Forensic Medical Examination** (Evidence collected within 120 hours of the assault) (18 and older) **Sexual Assault (Acute) Protocol: Anonymous Reporting Protocol:** Payment Requirements • SOVA Sexual Assault Protocol (SAP) Billing Statement must be submitted, • SOVA Medical Examination Release Form must be submitted, and • Payment requested within 180 days from the date of service. Important SOVA Medical Examination Release Form must be submitted with the following information: • The name of the Law Enforcement Agency. For anonymous reporting, when providing law enforcement information, write in "ANONYMOUS" instead of the name of the law enforcement agency. • To establish that the crime happened in SC, the incident location (city, county and state) is required. **NOTE:** Forms are located in the SLED protocol kit.
Sexual Assault (Chronic) Protocol **Criteria for payments:** • The assault occurred in South Carolina • The assault was reported to law enforcement • The exam was ordered by law enforcement Stipulations: SOVA will only pay for allowable charges incurred, in gathering evidence, when done at the request of law enforcement.	**Sexual Assault (Chronic) Protocol** (Evidence Collected after 72 hours of the assault) (17 and younger) Payment Requirements • Pages 1 and 2 of the Child Maltreatment Protocol billing statement is submitted, • Authorization and release form located in the Child Maltreatment Protocol is submitted, • Law Enforcement Incident Report listing each child as a victim, and • Payment must be requested within 180 days from the date of service.
Forensic Interview Evidence Collection Protocol **Criteria for payments:** • The assault occurred in South Carolina • The assault was reported to law enforcement • The forensic interview was ordered by law enforcement **Standards** • The interview must be performed using standards defined by SOVA. • Interviewer must have a Masters level degree • Interviewer must have completed a 40 hour specialized forensic interview training and must be licensed • Interviews must be conducted at a facility that follows a multi-disciplinary model and has been approved by SOVA	**Forensic Interview Evidence Collection Protocol** (Interviews ordered by law enforcement for children 17 years old and younger) Payment Requirements • Submit a billing invoice, • SOVA Forensic Interview Release Form, • SOVA Forensic Interview Report Form, • Law Enforcement Incident Report listing each child as a victim, and • Payment must be requested within 180 days from the date of Service Stipulations: SOVA will only pay for allowable charges incurred, in gathering evidence, when done at the request of law enforcement.

Helpful Hints for Providers:

SOVA assists victims of crime with out-of-pocket expenses, including crime-related Medical/Clinical/Dental treatment. All claims or applications for assistance must meet the eligibility criteria prior to consideration with crime related compensable expenses.

If you are billing SOVA for the first time, before you submit a bill	You will be required to register your business with the South Carolina State Government Procurement System at: http://procurement.sc.gov/PS/vendor/PS-vendor-registration.phtm **Then click on "New Vendor Registration"—the process consist of 9 basic steps, some of which are optional. Below are what's required:** • Your company's name and tax identification number • Information on the person responsible for maintaining the profile • Remit address (where checks should be mailed) • Entity designation (individual/sole proprietor, partnership, corporation)
Change in 'Remit' address(s)	You will be required to update your new information on the South Carolina State Government Procurement System at: http://procurement.sc.gov/PS/vendor/PS-vendor-registration.phtm • Click on "Update Vendor Information" • It may take up to 3 business days to update your information
If you have been assigned a new tax identification number (TIN)	You will be required to update your new information on the South Carolina State Government Procurement System at: http://procurement.sc.gov/PS/vendor/PS-vendor-registration.phtm • Click on "Update Vendor Information" • It may take up to 3 business days to update your information
New Owner of an existing business	You will be required to register your business with the South Carolina State Government Procurement System at: http://procurement.sc.gov/PS/vendor/PS-vendor-registration.phtm • Click on "New Vendor Registration"
State Employees	Providers who are state employees and who are sole proprietors, such as counselors, will be required to complete a dual employment application.
Unresolved Tax Issues/Tax Levy	Because SOVA is a state agency, providers who have unresolved tax issues might be required to resolve those issues before receiving payment from SOVA.
Conflict with the IRS	A provider could be required to provide verification from the IRS confirming that your Employer Identification Number (EIN) (TIN) is active. Information regarding your (EIN) (TIN) can be obtained from the IRS. (For information on how to obtain information from the IRS about the status of your EIN, see information below) 1-800-829-4933 (Business and Specialty Tax Line), then • Select option 1 for English, then • Select option 1 for EIN Department, then • Select option 3 for assistance with your request for a confirmation letter, then Request a 4158C, 147C or an EIN letter. Upon your request, you will receive a faxed cover sheet with the requested information and a letter will be sent to you from the IRS within 10 days. • And finally, you may fax the information to SOVA at (803) 734-2261. Pending payments will be mailed upon confirmation of your Employer Identification Number.

Documentation needed from Medical/Clinical/Dental providers:	Upon filing a claim, victims/claimants are required to provide SOVA with medical/Dental claim forms. One of the following forms is required for all separate crime related dates of service. • **UB-04 Medical Claim Form** • UB-92 Medical Claim Form • Health Insurance Medical Claim Form (CMS-1500) (HCFA-1500) • Itemized bill of Charges • ADA Dental Claim Form (w/treatment plan) • Itemized bill from vision center and when applicable, • Health insurance information - Explanation Of Benefit (EOB)
Documentation needed from Counselors: NOTE: SOVA's mental health policy provides an incremental approach to outpatient mental health sessions' limitation. This approach was implemented on July 1, 2012 and applies to all eligible and active claims. NOTE: The Provider must be a licensed mental health professional, who has received specific training in evidence based treatment that have been shown to be effective in meeting the need of crime victims.	For consideration with approved limits, providers will be required to provide the following: • SOVA Mental Health Counselor's Report for the initial 14 sessions • SOVA Additional Counseling Sessions Request form for additional sessions • Itemized bill of Charges or, • Health Insurance Medical Claim Form (CMS/HCFA-1500) • Explanation of Benefits (EOB) for each date of service SOVA CANNOT CONSIDER PAYMENT if medical claim forms, itemized billing information, and health insurance explanation of benefits statements (if applicable) have not been received.
Health insurance and EOBs	If the patient has health insurance, including Medicare or Medicaid, insurance must be billed. SOVA cannot consider payment until other payment sources, including health insurance, have been exhausted. For insured victims/ claimants, SOVA must have a copy of relevant insurance explanation of benefits (EOB) statements for each crime-related date of service. These may be submitted by the victim/claimant or the medical provider; however, providers should note that submitting EOBs along with medical claim forms or itemized billing information is encouraged, as it may expedite claims processing and payment.
Collections Activity: Section 16 3 1360: **Collection activities prohibited**	(A) When a person files a claim pursuant to this article, a health care provider that has received written notice of a pending claim is prohibited from all debt collection activities relating to medical and psychological treatment received by the person in connection with the claim until an award is made on the claim or the claim is determined to be non-compensable and is denied, or ninety days have passed after the health care provider first received notice of a pending claim. The statute of limitations for collection of the debt is suspended during the period in which the applicable health care provider is required to refrain from debt collection activities. (B) For purposes of this section, 'debt collection activities' means repeatedly calling or writing to the claimant and threatening to turn the matter over to a debt collection agency or to an attorney for collection, enforcement, or filing of other process. The term does not include routine billing or inquiries about the status of the claim." NOTE: If a victim/claimant has been placed in collections by a medical provider the account should be removed from collections immediately upon notification that a SOVA claim is pending.

Negotiating Bills	Due to increased claims for uninsured victims of crime, SOVA is duty-bound to negotiate a reduction of payment on behalf of victims. The maximum award amount for eligible crime victims in the State of South Carolina is $15,000. Because most crime victims **do not have any health insurance (private or public) and owe multiple providers more than the maximum payable dollar amount,** SOVA request that providers accept negotiated payment/settlement agreements as payment in full for victims' outstanding crime related debt and not balance bill the victims.
Release of Information	Each victim/claimant who submits a signed application to the State Office of Victim Assistance (SOVA), for assistance, authorize the State Office of Victim Assistance (SOVA) to request, obtain, and release any information or records to determine the eligibility of compensable bills.
Payer of last resort status	The State Office of Victim Assistance is recognized as the payer of last resort, meaning that other **collateral resources**, restitution, subrogation, civil settlement, health insurance (public or private), and hospital charity care, when applicable, **must be exhausted before SOVA will consider payment.**
Payment is prohibited prior to services being rendered	South Carolina's guidelines **specifically prohibit payment prior to services being rendered.** SOVA can only consider payment after services have been rendered and after required documentation has been received.
Checking status of a claim/payment	Because SOVA's checks are dispersed by the State of South Carolina, it may take up to thirty days from the time the payment has been processed for a provider to receive a reimbursement check or electronic payment. • SOVA does not notify medical providers automatically of claim status (awards or denials). Award notifications are sent to the victim/ claimant, who has the responsibility to notify medical providers of the claim status. • Due to the high volume of telephone inquiries medical providers are encouraged to submit faxed request for payment status. Medical providers seeking claim/payment status may send a faxed request to 803.734.1708. Status requests MUST include the victim's name, date of birth and Social Security Number. If the SOVA claim number is known, please include that as well. Please allow time for the research to be completed in order to respond to your request.
Timely Filing	SOVA highly recommends that claims be filed as soon as possible after services have been rendered to ensure prompt payments. However, SOVA requires providers to submit invoices and medical claim forms within 12 months from the date of service. Request for payment submitted after 12 months from the date of service will not be considered. **For new victim compensation claims/applications:** Claims (invoices/medical claim forms) for services provided must be submitted within 12 months after the date of eligibility.
Under the Compensation & the Sexual Assault Program, payments could be delayed for the	• Remit address was changed without notice • Remit address on the bill does not match information on W-9 • Billing name/name of facility does not match information on W-9

following reasons:	• Change in Tax Identification Number • Provider name change • Conflict with the IRS • Tax Levy • Dual employment
Under the Compensation & the Sexual Assault Program, payments could be denied for the following reasons:	• Missing law enforcement incident report for children 17 years of age or younger • The victim's name is not listed on the law enforcement incident report • Received past the 180 days filing deadline • Evidence collection protocol exam, for the crime date, has been paid • Victim's health insurance has paid • Follow up visits not covered • Chronic exam performed by someone other than a Physician, Nurse Practitioner, or SANE • Crime did not occur in SC
Maximum award limits:	Under the Compensation Program, all reimbursements are subtracted from the $15,000 maximum award amount. Under the Sexual Assault Program, SOVA reimburses from a fee schedule for evidence collection. For all medical treatment, as a direct result of physical injuries sustained during the assault, and for follow–up appointments, a victim compensation application will be required.

Mental Health Counseling Reimbursement

SUPPORTING DOCUMENTS REQUIRED

- **Mental Health Counselor's Report** form must be completed by the victim's counselor and must certify whether the psychological trauma being addressed is a direct result of the crime. This form is used for consideration with the initial 14 mental health session's limit. To request approval/preauthorization for payment of additional sessions, the 'Additional Counseling Sessions Request Form' must be submitted.
- **Medical claim form (HCFA-1500)/Itemized bill** from the mental health counselor detailing the actual dates of service, type of service provided (i.e. individual, group, medication management), the CPT code assigned, and the amount charged.
- **Explanation of Benefit (EOB):** Because SOVA is a payer of last resort, when the victim has health or dental insurance coverage (public or private), he/she will be required to provide SOVA with an Explanation of Benefits (EOB) from the Health insurance Company or provider for all crime related dates of service.

LICENSED PROFESSIONAL

SECTION 16-3-1180(A)(1) An award may be made for: reasonable and customary charges as periodically determined by the board for medical services, including mental health counseling, required and rendered as a direct result of the injury on which the claim is based, as long as these services are rendered by a licensed professional. Payment for mental health counseling is limited to the number of sessions during a one hundred eighty-day-period beginning on the date of the first counseling session or twenty sessions, whichever is greater. Upon recommendation of the director, the board may allow victims who max out the current benefit of twenty mental health counseling sessions to request up to an additional twenty sessions for a total of forty sessions;

POLICY

- The Provider must be a Licensed Mental Health Professional, and
- The Provider must have received specific training in evidence based treatment that has been shown to be effective in meeting the needs of crime victims.

INCREMENTAL LIMIT POLICY:

SOVA's mental health policy provides an incremental approach to outpatient mental health session limitations. This approach was implemented on July 1, 2012 and applies to all eligible and active claims. Please note that this approach complies with SOVA's law.

<u>This policy in no way replaces SECTION 16-3-1180; it is in compliance with the law:</u>

As long as these services are rendered by a licensed professional; payment for mental health counseling is limited to the number of sessions during a one hundred eighty-day-period beginning on the date of the first counseling session or twenty sessions, whichever is greater. Upon recommendation of the director, the board may allow victims who max out the current benefit of twenty mental health counseling sessions to request up to an additional twenty sessions for a total of forty sessions:

- For the initial 14 mental health session's limit, providers will be required to submit a Mental Health Counselor's Report.
- Approval/Pre-Authorization will be required for each additional incremental limit.
- The request for additional sessions must be reviewed and approved before additional sessions can be considered for payment.
- SOVA will review each subsequent request with an emphasis on any extreme circumstance of the victim.
- Sessions provided beyond the authorized session's incremental limit are subject to denial if the additional sessions provided are not approved.

NOTE: SOVA pays the outstanding balance from bills not fully covered by existing medical insurance. If a victim has private or public medical insurance to include Medicaid/Medicare, bills must first be filed with applicable companies/ carriers before submission to the agency for possible payment.

NOTE: Family sessions are reimbursed using the individual counseling fee scale.
NOTE: SOVA does not reimburse LMSW's practicing privately or independently for clinical services, including mental health counseling.
NOTE: Counseling sessions for offenders are not compensable under the Victim Compensation Program.

Mental Health Counseling Reimbursement Cont.

Revisions as of July 2014

SOVA no longer requires the use of CPT codes when billing for counseling sessions. Providers are simply required to provide a description of the service and time spent. Reimbursement amount will be based on a fixed fee scale per session and is considered after any other 3rd party payee responsibility.*

Unit of Service	Unit of Service	Unit of Service	Unit of Service
Initial Session (which can be up to 2 hours)	Half session (20-30 minutes)	Full Session (45-60 minutes)	1½ Session (75-90 minutes)

Fee Schedule for Services Per Unit

Individual Counseling:

- LMSW, LPCI - $75.00 per unit
- Supervised PHD (Psychi/o) Candidate Interns - $75.00 per unit
- LPC, LCSW, LMFT, LISW - $90.00 per unit
- PHD Clinical Psychology - $105.00 per unit
- MD - $105.00 (Include: medication management) per unit

Group Counseling:

- LMSW, LPCI - $37.50 per unit
- Supervised PHD Candidate interns -$37.50 per unit
- LPC, LCSW, LMFT & LISW $45.00 per unit
- PHD Clinical Psychology -$52.50 per unit
- MD $52.50.00/hr. (include: medication management) per unit

Payer of Last Resort Status

*The State Office of Victim Assistance is the payer of last resort. If the victim has insurance, and the victim elects not to use his/her insurance for treatment, SOVA will not cover the cost. It is the provider's responsibility to ensure that other avenues of payments are explored and used.

Clinicians Billing SOVA For The First Time After October 1, 2014

Must submit documented evidence of the following:

- Copy of professional license
- Specific training in the use of evidence based treatment models that have been shown to be effective in meeting the needs of crime victims.

Timely Filing

- SOVA highly recommends that claims be filed as soon as possible after services have been rendered to ensure prompt payments when authorized. However, SOVA requires providers to submit invoices and medical claim forms within 12 months from the date of service. Requests for payment submitted after 1 year from the date of service will not be considered.
- For new victim compensation claims/applications: Claims (invoices/medical claim forms) for services provided must be submitted within 12 months after the date of eligibility.

Payment Stipulation

- Providers seeking reimbursement from SOVA must agree to all Mental Health Counseling guidelines and not balance bill the victim.

SOVA: Dental Billing – Fee Schedule

ADA Code		*SOVA Rate*
D0140	Limited oral evaluation-problem focused	***44***
D0150	Comprehensive oral evaluation	***63***
D0160	Detailed and extensive oral evaluation problem focused	***142***
D0210	Intraoral – complete series (including bitewings	***96***
D0220	Intraoral periapical first film	***25***
D0230	Introral periapical additional film	***23***
D0250	Extraoral First Film	***43***
D0260	Extraoral Additional Film	***40***
D0270	Bitewing 1 Film	***21***
D0277	Vertical bitewings	***72***
D0330	Panoramic film	***83***
D2330	Resin-based composite-1 surface anterior	***117***
D2331	Resin-based composite-2 surfaces anterior	***144***
D2332	Resin-based composite-3 surfaces anterior	***177***
D2335	Resin-based composite-4 or more surfaces	***215***
D2391	Resin-based composite-one surface, posterior	***144***
D2392	Resin-based composite one surface, posterior	***180***
D2393	Resin-based composite-three surface, posterior	***185***
D2394	Resin-based composite-four or more surfaces, posterior	***286***
D2710	Crown-resin (indirect)	***414***
D2740	Crown-porcelain/ceramic substrate	***929***
D2750	Crown-porcelain/fuse high noble mtl	***887***
D2751	Crown porcelain fused to predominantly base metal	***881***
D2752	Crown-porc/noble metal	***887***
D2910	Recement inlay	***81***
D2920	Recement crown	***91***
D2950	Core buildup, including any pins	***200***
D2952	Cast post & core in additional to crown	***338***
D2954	Prefabricated post & core in additional to crown	***185***
D2962	Porcelain laminate vene (labial veneer-laboratory)	***800***
D3330	Molar root canal	***798***
D3310	Anterior root canal (excluding final restoration)	***539***
D3320	Bicuspid root canal (excluding final restoration)	***651***
D4263	Bone replacement graft-first site in quadrant	***
D5110	Complete upper denture/maxillary	***1020***
D5120	Complete lower denture/mandibular	***1020***
D5211	Partial upper denture-resin base (clasps & rests)	***917***
D5212	Partial lower denture	***1066***
D5214	Partial lower denture, cast metal frame with resin base	***1014***
D5225	Max partial denture (valplast)	***782***
D5226	Mand. Partial denture (valplast)	***782***
D5520	Repair broken or missing teeth	***99***
D5610	Repair resin denture base	***129***
D5650	Add tooth, existing partial denture	***144***
D5810	Interim complete denture	***450***
D5811	Interim complete denture	***450***
D6040	Implant/surgical placement	***1530***
D6053	Implant	***1148***
D6057	Placement/custom abutment	***765***
D6058	Abutment supported porcelain/ceramic crown	***709***

SOVA: Dental Billing – Fee Schedule cont.

ADA Code		*SOVA Rate*
D6067	Implant-crown high noble metal	***1109***
D6078	Implant-supported removable partial	***1600***
D6240	Pontic bridge porc. & prec metal	***944***
D6241	Pontic-porcelain fused to base	***881***
D6252	Pontic-resin w/noble metal	***508***
D6545	Retainer-cast metal resin	***450***
D6750	Crown porcelain fused/retainer; porc-hi nobel/brg-crn	***882***
D6751	Crown-porcelain fused – abutment crn-porc fuse-base met	***881***
D6760	Retainer porc fused	***944***
D7140	Extraction, erupted tooth/extraction-single tooth	***107***
D7210	Extraction, surgical removal of erupted tooth	***206***
D7230	Extraction, removal of impacted tooth-partially bony	***343***
D7250	Surgical removal of residual tooth roots	***210***
D7272	Tooth transplantation	***513***
D9215	Local anesthesia conjunction operative/surg pra	***29***
D9220	Deep sedation/general anesthesia/sedation IV	***300***
D9221	Deep sedation/general anesthesia-ea add 15 min	***155***
D9230	Inhalation of nitrous oxide/anxilysis analge	***57***
D9241	IV conscious sedation/intravenous conscious sedation	***341***
D9242	IV conscious sedation/analg – ea add 15 min	***131***
D9420	Hospital Call	***151***
D9440	Office visit after regularly scheduled hours	***51***
20530	Removal foreign body	***181***
96360	IV infusion	***54***
99241	Office conslt 15min	***44***
99242	Office conslt 30 min	***83***
99243	Office conslt 40min	***114***
99358	Evaluation/management serv.	***103***
40805	Removal of embedded foreign body	***798***

Payer of Last Resort:

SOVA is an eligibility program. All submitted compensable expenses will be offset by other available sources before reimbursements/payments are considered. Pursuant to public and private dental/health insurance guidelines regarding In-Network providers, timely filing and pre-authorization, victims are encouraged to provide his/her provider their insurance information. Not doing so could mean a denial of our claim at SOVA. Victims will be required to file all compensable expenses with his/her private or public dental/health insurance company/carrier first; this includes Medicaid and Medicare. Victims' compensable expenses are also offset by restitution, subrogation or civil settlements. Because SOVA is not a guarantor for crime victims' compensable expenses, providers are encouraged to mail all bills to victims and forward ADA/UBs/HCFAs etc. to SOVA.

*****Maximum Award Limits:**

The maximum award amount for eligible crime victims in the State of South Carolina is $15,000. All reimbursements are subtracted from the maximum award amount. Due to increased claims for uninsured victims of crime, SOVA is duty-bound to negotiate a reduction of payment on behalf of victims. All crime related Oral and Maxillofacial surgery, Bone replacement graft and most implants are reimbursed at a 15% - 50% reduction provided that sufficient funds are available. To ensure reimbursement for crime related services, providers are encouraged to contact the office for pre-approval.

PART FOUR:

SAMPLE FORMS

SAMPLE FORMS

PROCESSABLE FORMS

SOVA accepts the following forms when considering payment/reimbursement:

UNPROCESSABLE FORMS

SOVA does not accept the following forms when considering payment/reimbursement:

- Final notices
- Statements
- Bills that are not itemized
- Incomplete bills (missing information)
- Cash register receipts from pharmacy
- Incomplete receipts from pharmacy
- Collection notices

Disclaimers:

Any information submitted on the forms is fictitious and intended for sample purposes only. Actual forms will reflect real data entered by providers. This site also includes forms from organizations other than SOVA and has been provided for sample purposes only.

The processable forms listed may change without notice and all submitted forms are subjected to verification, which may delay the process. SOVA may also require additional documentation.

ADA Dental Claim Form

2015 Edition

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)

☐ Statement of Actual Services Ð OR Ð ☐ Request for Predetermination / Preauthorization

☐ EPSDT/ Title XIX

2. Predetermination / Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Subscriber Identifier (SSN or ID#)
9. Plan/Group Number	10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Subscriber Identifier (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	19. Student Status ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	

21. Date of Birth (MM/DD/CCYY)	22. Gender ☐ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. Provider ID	50. License Number	51. SSN or TIN

52. Phone Number ( ) Ð

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☐ Provider Os Office ☐ Hospital ☐ ECF ☐ Other	39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)	41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining	43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) / 44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)	47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X _____
Signed (Treating Dentist) Date

54. Provider ID	55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) Ð	58. Treating Provider Specialty

1	2	3a PAT. CNTL #		4 TYPE OF BILL
		b. MED. REC. #		
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH 7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTH DATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a															a
b															b

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1								1
2								2
3								3
4								4
5								5
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21								21
22								22
23		PAGE ____ OF ____	CREATION DATE		TOTALS			23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED 'S NAME	59 P. REL	60 INSURED 'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A					A
B					B
C					C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			A
B			B
C			C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS	81CC			
	a			
	b			
	c			
	d			

76 ATTENDING	NPI		QUAL	
LAST		FIRST		
77 OPERATING	NPI		QUAL	
LAST		FIRST		
78 OTHER	NPI		QUAL	
LAST		FIRST		
79 OTHER	NPI		QUAL	
LAST		FIRST		

2015 Edition

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

UB-92 Claim Form Example

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1	County Hospital 551 West Street Anytown, IL 60066	2		3 PATIENT CONTROL NO 7654321-001						4 TYPE OF BILL
		5 FED. TAX NO 37-7654123	6 STATEMENT COVERS PERIOD FROM 07-01-05	THROUGH 07-31-05	7 COV'D	8 INC'D	9 C.I.D	10 L.R.D	11	
12 PATIENT NAME Doe Child		13 PATIENT ADDRESS 1234 East Street, Anytown, IL 60066								
14 BIRTH-DATE 02-24-2004	15 SEX F	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 CHR	22 STAT	23 MEDICAL RECORD NO.	24 25 26 27 28 29 30 CONDITION CODES 31
32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	35 OCCURRENCE CODE / DATE	36 OCCURRENCE SPAN CODE / FROM / THROUGH						37
a b										A B C
38 Doe Child 1234 East Street Anytown, IL 60066		39 VALUE CODES CODE / AMOUNT		40 VALUE CODES CODE / AMOUNT		41 VALUE CODES CODE / AMOUNT				
		a b c d	-	-	-	-	-	-		

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1		Physical Therapy	97110	071205	4	100. 00	-		1
2		Physical Therapy	97110	071405	4	100. 00	-		2
3		Physical Therapy	97110	072005	4	100. 00	-		3
4		Physical Therapy	97110	072205	4	100. 00	-		4
5						-	-		5
6						-	-		6
7						-	-		7
8						-	-		8
9						-	-		9
10						-	-		10
11						-	-		11
12						-	-		12
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18						-	-		18
19						-	-		19
20						-	-		20
21						-	-		21
22						-	-		22
23						400. 00	-		23

	50 PAYER	51 PROVIDER NO.	51 REL. INFO	53 ASG. BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A B C					-	400. 00	POS - 11
57					DUE FROM PATIENT ▶		

	58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - H.IC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A B C	Doe, Child		EI 155155		

	63 TREATMENT AUTHORIZATION CODES	64 ESC.	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A B C				

67 PRIN. DIAG. CD	68 CODE	69 CODE	OTHER DIAG. CODES 70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
V571											

79 P.C.	80 PRINCIPAL PROCEDURE CODE / DATE	81 OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	83 OTHER PHYS. ID

	84 REMARKS	OTHER PHYS. ID	85 PROVIDER REPRESENTATIVE	86 DATE
a b c d	Therapist - Ann Therapist Associate Level Provider - Peggy Associate		X	

UB-92 HCFA-1450 OCR/ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Form Approved
OMB No. 0960-0566

2015 Edition

Social Security Administration

Consent for Release of Information

Please read these instructions carefully before completing this form.

When to Use This Form

Complete this form only if you want the Social Security Administration to give information or records about you to an individual or group (for example, a doctor or an insurance company).

Natural or adoptive parents or a legal guardian, acting on behalf of a minor , who want us to release the minor's:

- nonmedical records, should use this form.
- medical records, should not use this form, but should contact us.

Note: Do not use this form to request information about your earnings or employment history. To do this, complete Form SSA-7050-F4. You can get this form at any Social Security office.

How to Complete This Form

This consent form must be completed and signed only by:

- the person to whom the information or record applies, or
- the parent or legal guardian of a minor to whom the nonmedical information applies, or
  the legal guardian of a legally incompetent adult to whom the information applies.

To complete this form:

- Fill in the name, date of birth, and Social Security Number of the person to whom the information applies.
- Fill in the name and address of the individual or group to which we will send the information.
- Fill in the reason you are requesting the information.
- Check the type(s) of information you want us to release.
- Sign and date the form. If you are not the person whose record we will release, please state your relationship to that person.

PRIVACY ACT NOTICE : The Privacy Act Notice requires us to notify you that we are authorized to collect this information by section 3 of the Privacy Act. You do not have to provide the information requested. However, we cannot release information or records about you to another person or organization without your consent for release of information. Your records are confidential. We will release only records that you authorize, and only to persons or organizations who you authorize to receive that information.

PAPERWORK REDUCTION ACT STATEMENT : This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questionsSEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213. You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 212345-6401. Send only comments relating to our time estimate to this address, not the completed form.

Form Approved
OMB No. 0960-0566

Social Security Administration

Consent for Release of Information

TO: Social Security Administration

_____ _____ _____

Name Date of Birth Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS
_____	_____
_____	_____
_____	_____
_____	_____

I want this information released because :

_____

_____

(There may be a charge for releasing information.)

Please release the following information:

_____ Social Security Number
_____ Identifying information (includes date and place of birth, parents' names)
_____ Monthly Social Security benefit amount
_____ Monthly Supplemental Security Income payment amount
_____ Information about benefits/payments I received from _____ to _____
_____ Information about my Medicare claim/coverage from _____ to _____
(specify) _____
_____ Medical records
_____ Record(s) from my file (specify) _____
_____
_____ Other (specify) _____

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: _____
(Show signatures, names, and addresses of two people if signed by mark.)

Date: _____ Relationship: _____

Form SSA-3288 (5-2007) EF (5-2007)

SOVA: Certificate of Clinical Necessity

07/14

State Office of Victim Assistance 1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC 29201 803.734.1900

Crime Victim Information:

Victim:_____ **Claim#:** _____
SS# (last 5 digits):_____ **Crime Date:** _____
DOB:_____ **Crime Type:** _____

To the Treating Clinician: It appears that the victim has a pre-existing medical condition (a condition that existed prior to the crime or a condition that does not appears to be directly related to the crime on which his/her claim is based. To assist with this assessment, the victim is required to provide the agency with a Certificate of Clinical Necessity from his/her treating Physician/Clinician certifying that the treatment is directly related to the crime on which the claim is based and that the expense(s) incurred for the treatment are crime related.

(1) In your professional opinion, do you certify with a reasonable degree of professional certainty that the □ **treatment or** □ **office visit** was reasonable, necessary and was directly related to the injury sustained during the crime?

Crime Date:_____ Type of Crime: _____☐Yes ☐No

(2) Diagnosis:

_____

_____

(3) Service Provided/Recommended Service: (Must include ICD-9 Codes/Procedure Codes)
ICD-9 Codes: _____ _____ _____
Procedure Codes: _____ _____ _____
List Medication(s): _____ _____ _____

_____

_____

_____

(4) Clinician's Statement of Justification: The treatment must be directly related to the above listed crime. (NOTE: This means that the crime must have either caused the injury or aggravated a pre-existing condition.)

_____

_____

_____

_____

_____

(5) Expected Duration of Treatment _____Months

I certify that any statement hereto has been reviewed and signed by me. I certify that the information is true, accurate and complete, to the best of my knowledge.

Type or print Clinician's name _____ Phone :(___) _____

Clinician's Signature_____ Date:_____

Clinician's Address_____

Please have your Clinician fax this form to 803.734.2261 **Form PSD001**

SOVA: Certificate of Dental Necessity

07/14

State Office of Victim Assistance 1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC 29201 803.734.1900

Crime Victim Information:

Victim:_____ **Claim#:**_____

SS#: (last 5 digits)_____ **Crime Date:**_____

DOB:_____ **Crime Type:**_____

To the Dentist: It appears that the victim has a pre-existing condition (a condition that existed prior to the crime or a condition that does not appears to be directly related to the crime on which his/her claim is based. To assist with this assessment, the victim is required to provide the agency with a Certificate of Dental Necessity from his/her treating provider certifying that the treatment is directly related to the crime on which the claim is based and that the expense(s) incurred for the treatment are crime related.

(1) In your professional opinion, do you certify with a reasonable degree of professional certainty that the □ **treatment or** □ **office visit** was reasonable, necessary and was directly related to the injury sustained during the crime?

Crime Date:_____ Type of Crime:_____ ☐Yes ☐No

(2) Diagnosis:

_____

_____

(3) Service Provided/Recommended Service: Must include tooth number(s), procedure code(s) and description(s)

_____

_____

_____

(4) Dentist's Statement of Justification: The treatment must be directly related to the above listed crime. (NOTE: This means that the crime must have either caused the injury or aggravated a pre-existing condition)

_____

_____

_____

_____

_____

_____

(5) Expected Duration of Treatment _____Months

I certify that any statement hereto has been reviewed and signed by me. I certify that the information is true, accurate and complete, to the best of my knowledge.

Type or print Dentist's name_____ Phone:(___)_____

Dentist's Signature_____ Date:_____

Dentist's Address_____

Please have your Clinician fax this form to 803.734.2261 **Form PSD002**

SOVA | Mental Health Counselor's Report

Rev. 08/14

State Office of Victim Assistance 1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC 29201 Phone: 803.734.1900 Fax: 803.734.2261

Today's Date _____/_____/_____

Victim's Legal Name _____ Claimant *(if a different person)* _____

SS # (last 5 digits) ___ - ___ ___ ___ ___ Crime Date ___/____/_____

To the Provider: This form is used for consideration with the initial 14 mental health session's limit. To request approval/preauthorization for payment of additional sessions, the 'Additional Counseling Sessions Request Form' must be submitted.

This form must be submitted to request approval/preauthorization for payment of counseling sessions. The treatment must be directly related to the crime on which the claim is based. The information provided must include a goal-directed treatment plan and a summary of your assessment toward meeting those goals.

Approval/preauthorization is contingent upon the rationale behind the need and the details provided.

Is the trauma and the treatment a direct result of this crime? YES _____ NO _____

Presenting Issue: _____

Description of psychological trauma as related to victimization: _____

Type of evidence based treatment model being used: _____

Payer of Last Resort Status:
The State Office of Victim Assistance is the payer of last resort. If the victim has insurance, and the victim elects not to use his/her insurance for treatment, SOVA will not cover the cost. It is the provider's responsibility to ensure that other avenues of payments are explored and used.

The following question must be answered: Does this victim have health insurance coverage? YES ___ NO
If the victim has health insurance, SOVA will pay after the insurance pays. Please provide the following information along with a copy of the EOB for each DOS:

Heath Insurance Carrier _____ Policy No. _____

Authorized Signature of Treating Therapist/Counselor	**Printed Name of Payee**	**(_____)_____ Telephone No./Extension**
License Type and Number	**Mailing Address**	**City/State/Zip Code**
Supervisor's Signature	**License Type and No.**	**Date**

SOVA | Additional Counseling Sessions Request Form

Rev. 07/14

State Office of Victim Assistance 1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC 29201 Phone: 803.734.1900 Fax: 803.734.2261

Today's Date ____/____/____ Date of this victim's first session: ____/____/____

- SOVA's mental health policy provides an incremental approach to outpatient mental health sessions' limitation.
- This form must be submitted to request approval/preauthorization for payment of additional sessions.
- Approval/preauthorization is contingent upon the rationale behind the need and the details provided.
- The information provided must include a goal-directed treatment plan and a summary of your assessment toward meeting those goals.

Specific training and qualification: The provider must be a Licensed Mental Health Professional, who has received specific training in evidence based treatment that have been shown to be effective in meeting the needs of criminal victimization on adults, children and families.

Victim's Legal Name _____ Claimant (if a different person) _____

SOVA Claim# _____ Crime Date: _____

Briefly describe the symptoms/conditions you are treating that are a **direct** result of the crime.

Provide the multiaxial diagnosis: _____

Has there been substantial progress toward recovery from the crime related condition?

☐ **YES** ☐ **NO**

Estimate duration of treatment: From _____ To _____ How many additional sessions are you requesting? ____

Treatment Plan:

1) What is your diagnosis? _____

2) What is your Evidence Based Treatment model? _____

_____

3) What is your training in the use of this model? _____

_____

4) What is your plan for termination?

_____

_____

_____

The Provider must provide the following information: The victim/claimant must sign and date this form:

_____ _____

Provider: Print Name, License Type - Number Victim/Claimant: Name and Date

_____ _____

Name of Facility/Business Phone Number

SOVA | Funeral Bill Case Status Form

07/14

State Office of Victim Assistance 1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC 29201 Fax#: 803.734.4022

BUSINESS NAME	ADDRESS	PHONE NUMBER	TAX ID NUMBER

Decedent's Name: _____ DOB _____

Person who signed the itemized funeral bill/contract/"Billing To" Person: _____

Beginning Balance of the Bill: _____

Current Balance of the Bill: _____

Is Life Insurance Pending? _____

Has Life Insurance Been Applied to the Account? _____ If so, how much? _____

Who is the Beneficiary/Beneficiaries? _____

Please list all paying parties and their contact information, dollar amount, and method of payment below:

NAME	ADDRESS	PHONE NUMBER	DOLLAR AMOUNT	METHOD OF PAYMENT	DATE OF PAYMENT

(Please attach a copy of the itemized funeral bill/contract)

_____ _____

Print Name and Title of Person Completing this Form Date

State Office of Victim Assistance
1205 Pendleton St., Brown Bldg., Room 401
Columbia, SC 29201
Business Line: 803.734.1900
www.sova.sc.gov

Please be advised that any information that is provided with fraudulent intent will be immediately reported to the SC Department of Labor, Licensing and Regulations.

SOVA | Memorandum of Understanding

07/14

State Office of Victim Assistance 1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC 29201 Fax#: 803.734.4022

Date: _____

As a public service to the citizens of this state, SOVA has developed this "Memorandum of Understanding." This document does not replace SOVA's Crime Victim Compensation Application.

This is a "Memorandum of Understanding" between_____ (Name of Establishment) and _____ (Claimant).

_____ **I understand that the State Office of Victim Assistance (SOVA) is an eligibility program with criteria that must be met.**
_____ **I have been informed that if the compensation claim meets all of the criteria, there is a $4,000.00 maximum limit for funeral services and all balances are my responsibility.**
_____ **I understand that SOVA, in its sole discretion, pursuant to its laws, may grant a full award, reduce an award or deny a claim.**
_____ **I acknowledge that by signing this document, that:**

1. **This information has been explained to me by my victim advocate or by the Director of this establishment.**
2. **I agree to fully adhere to all rules and regulations of the State Office of Victim Assistance.**
3. **I understand that the eligibility process could take up to 120 days from the date that SOVA receives the compensation application.**

I recognize that by signing this document, I acknowledge that submitting the Crime Victim Compensation application to SOVA is not an approval for payment, but the initial process for consideration with payment.

Signing this memorandum signifies or represents an understanding between the facility and the customer listed above.

_____		_____	
PROVIDER/DIRECTOR:		CUSTOMER/FAMILY MEMBER:	
_____	_____	_____	_____
NAME (PRINT):	DATE	NAME (PRINT):	DATE
_____		_____	
SIGNATURE:		SIGNATURE:	

Disclaimer

Payer of Last Resort:

SOVA is an eligibility program. All eligible compensable expenses will be offset by other available sources before reimbursements/payments are considered. Recipients will be required to exhaust all available funds before the program will consider payments. This includes subrogation (monies awarded for civil actions), restitution (monies ordered by the courts), pre-need arrangements and donations.

State Office of Victim Assistance
1205 Pendleton St., Brown Bldg., Room 401
Columbia, SC 29201
Business Line: 803.734.1900
www.sova.sc.gov

SOVA | Employer's Report – Lost Wages/Support

PSD25 07/14

State Office of Victim Assistance 1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC 29201 Fax#: 803.734.4022

WWW.SOVA.SC.GOV **** Click on payment and reimbursement guide under the "For Providers" tab for more information

Criteria for Lost Wages

There are four criteria that must be met: Employment (2) Missed time from work (3) Reportable income & (4) Disability

To the Employer: This form must be completed by your Payroll Office or Human Resource Department.
Please complete this form and return it directly to our office as soon as possible, fax is acceptable: 803.734.2261

Legal name of the injured employee (crime victim) _____

Job Type_____ Social Security # (Last 5 digits) _____ Date of Birth ____/____/____

Date the above person was first employed by you ____/_____/_____

Date he/she was first absent due to the crime related injury/injuries ____/_____/_____

Date he/she returned to work part time (if applicable) ____/_____/_____

Comment: _____

Date he/she returned to work full time____/_____/_____

Date he/she was terminated if no longer employed by you ____/_____/_____

Please provide an explanation _____

Because SOVA is a payer of last resort, all sources such as annual or sick leave, long/short term disability, SSA/SSI must be exhausted before SOVA will consider lost wage benefits.

Average work hours per week _____ Average hourly wage _____ Gross salary per week _____

Was this employee compensated for time absent from work? ____Yes _____ No
If you answered yes, complete the following:

Deduction	Amount Per Week	From Date	To Date
Unemployment	$		
Vacation	$		
Sick	$		
Disability	$		
Other (specify)	$		

Employer_____ Address_____ Phone (___) _____

Person Completing Form (print) _____ Signature_____

Title_____ Date_____ Employer Identification Number (required) _____

**Further documentation may be required to receive lost wages/support, i.e. two pay stubs prior to the crime or copies of your last two consecutive years of your federal income tax return transcript (contact IRS for additional information 1.800.829.1040)

SOVA | Self-Employment Verification of Lost Wages

PSDL23 07/14

State Office of Victim Assistance 1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC 29201 Fax#: 803.734.4022
WWW.SOVA.SC.GOV **** Click on payment and reimbursement guide under the "For Providers" tab for more information

This form applies to you:

- **If** you were self-employed at the time of the crime
- **If** you received your earnings in cash, personal checks or money order
- **If** you received your earnings in tips
- **If** you reported your income to the IRS

To support your request for lost wages, you must:
• Complete this form • Return this form to SOVA (NOTARIZED), along with a completed Physician Disability Report from your Treating Physician • Provide copies of the last two consecutive years of your federal income tax return transcript: (Free tax return transcripts may be requested from the Internal Revenue Services (IRS) by phone (1.800.829.1040 or 1.800.908.9946) or by mail using form 4506T available at http://www.irs.gov/pub/irs-pdf/f4506t.pdf.

Criteria for Lost Wages

There are four criteria that must be met:
(1) Employment (2) Missed time from work (3) Reportable income & (4) Disability

Section 1 Victim Information (the person requesting lost wages)

Legal Name_____ Business Name_____
SS# (last 5 digits) _____ DOB_____ SOVA Claim Number_____ Crime Date_____
Home Address _____Contact #_____
City_____ State_____ Zip Code_____

Section 2 Description of your work

_____
_____

Section 3 Describe how the crime directly impacted your ability to work

_____
_____

1) What was the starting date of your self-employment/business? _____
2) What was the date you were first unable to report to work? _____
3) What date did you return to work? _____part time _____full time
4) Average number of hours worked per week? _____

SUBSCRIBED AND SWORN TO BEFORE ME BY _____
THIS _____ DAY OF _____, 20_____. **Place Seal Here**
MY COMMISSION EXPIRES _____
NOTARY PUBLIC _____ (signature)
VICTIM/CLAIMANT _____ (signature)

SOVA | Physician's Disability Report – Lost Wages PSD26 07/14

State Office of Victim Assistance 1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC 29201 Fax#: 803.734.4022
WWW.SOVA.SC.GOV **** Click on payment and reimbursement guide under the "For Providers" tab for more information

Criteria for Lost Wages

There are four criteria that must be met:
(1) Employment (2) Missed time from work (3) Reportable income & (4) Disability

Your Treating Physician must complete this form to confirm your inability to work as a direct result of the incident. Your Physician should return this form directly to our office by fax 803.734.2261 or US mail (see below for address). For questions, please contact us at 803.734.1900.

Legal name of (crime victim) injured patient_____

Social Security # (Last 5 digits) _____ Date of Birth ____/____/____

Date the patient (crime victim) was first seen by you in relation to the crime____/____/____

Date of crime related injury ____/____/____ (must be completed)

Briefly describe the injury/injuries sustained as a direct result of the crime:_____

_____

Treating Physician must provide a start and end date of the disability period

Patient will be totally unable to work from ____/____/____ through ____/____/_____

Check all that applies in accordance to the patient's physical ability:

- ☐ May resume work immediately without restrictions
- ☐ May resume work immediately with the following restrictions_____
  _____
- ☐ Patient may return to work at full capacity on (date) ____/_____/_____
- ☐ Patient may return to work at partial capacity on (date) ____/_____/_____
- ☐ Patient has a return appointment on (date) ____/_____/_____

Type or print Treating Physician's name_____ Phone (____) _____

Signature of Treating Physician_____ Date_____

Name and Address of Facility _____

State Office of Victim Assistance
1205 Pendleton Street, Brown Bldg., Room 401
Columbia, South Carolina 29201

SOVA | Physician's Disability – Loss of Support – Report

PSD24 07/14

State Office of Victim Assistance 1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC 29201 Fax#: 803.734.4022
WWW.SOVA.SC.GOV **** Click on payment and reimbursement guide under the "For Providers" tab for more information

This form applies to you:

- **If** you are the Spouse of the direct victim or the Parent/Legal Guardian of a minor child victim who sustained a physical injury and requires individual care
- **If** the direct victim's Treating Physician certifies that it is medically necessary for you to provide individual care to the direct victim who sustained the injury
- **If** it is medically necessary for you to miss more than two consecutive weeks from work

To the Direct Victim's Treating Physician:
In your professional opinion, do you certify with a reasonable degree of professional certainty that the victim requires individual care from the spouse or parent/legal guardian, and the care is required for at least two consecutive weeks?
_____Yes _____No

If you answered yes,
Provide the name of your patient:_____
Provide the date of the crime:_____

Section 1 Spouse or Parent/Legal Guardian Information (The person requesting loss of support)

Legal Name_____ SS# (last 5 digits) _____ DOB_____
SOVA Claim Number_____ Crime Date_____
Home Address _____Contact #_____
City_____ State_____ Zip Code_____

Section 2 To be completed by the Treating Physician

Describe the injury/injuries sustained as a direct result of the crime:_____
_____
Describe the care that is medically necessary to be provided by the spouse or parent/legal guardian of the direct victim:
_____
_____

Care will be required from _____/_____/_____ through _____/_____/_____

Type or print Treating Physician's name_____ Phone (____)_____
Signature of Treating Physician _____ Date_____
Name and Address of Facility _____

Section 3 To the Spouse or Parent/Legal Guardian of the Direct Victim

Criteria: For lost wages there are four criteria that must be met: (1) Employment ** SOVA Employment Report or SOVA Self-Employment Verification of Lost Wages Form **(2) Missed time from work (3) Reportable income & (4) Disability.
Limitations: If you qualify, SOVA will consider loss of support benefits for a period not to exceed one month.
Payer of Last Resort Status: Because SOVA is a payer of last resort, all sources such as annual or sick leave, long/short term disability and SSA/SSI must be exhausted before SOVA will consider lost wage benefits.
Lost Wages Compensation Rate: SOVA uses an established based amount to calculate lost wage benefits.

SOVA
South Carolina State Office of Victim Assistance
An Office of the Governor

SOVA | Sexual Assault Protocol (SAP) Billing Statement PSD003 07/14

Name (last, first, MI):_____ **SS#:** _____/_____/_____

DOB: _____/_____/_____ **Age:** _____ **Gender:** ☐ **Male** ☐ **Female**

Ethnicity: _____ **Race:** _____

Home Address: _____

City:_____ **State:** _____ **Zip Code:**_____

Name of Healthcare Provider: _____ **ACC#:**_____

Contact Number (_____) _____-_____ **Date of Service: (mm/dd/yy)** ____/____/___

Laboratory Services

☐ **Gonorrhea Culture**
- ☐ Oral ($12)
- ☐ Rectal ($12)
- ☐ Vaginal ($12)

☐ **Chlamydia Culture**
- ☐ Oral ($12)
- ☐ Rectal ($12)
- ☐ Vaginal ($12)

☐ NAAT ($50)
☐ Herpes Culture ($20)
☐ Vaginal Culture ($20)
☐ Wet Prep/KOH Prep ($10)
☐ Serum Pregnancy Test ($25)

☐ **Gram Stain**
- ☐ Urethral ($10)
- ☐ Rectal ($10)
- ☐ Vaginal ($10)

☐ RPR, VDRL, Syphilis ($10)
☐ Presence of motile sperm ($5)
☐ Hepatitis B ($40)
☐ HIV HTLVI ($20)
☐ Urinalysis ($18)
☐ Blood Drawing Fee ($5)
☐ Urine Culture ($20)
☐ Urine Pregnancy Test ($20)

Medical Services

☐ Physician, FNP, NP Fee ($105)
☐ Emergency Room Fee ($75)
☐ SANE Fee ($80)
☐ Colposcopy Fee ($90)
☐ Clinic Fee ($50)
☐ Supplies ($12)

Medications

Medication	Fee	Qty	Medication	Fee	Qty
☐ Rocephine (Ceftriaxone) (injection)	$85 ea		☐ Plan B Levonorgestrel Flagyl	$25 ea	
☐ Flagyl (Metronidazole) (tabs/ea)	$3 ea		☐ Ovral (Norgestrel) (tabs/each)	$1.75 ea	
☐ Phenergen (Promethazine) (tabs/ea)	$2.20 ea		☐ Zithromax (Azithromycin) (tabs/ea)	$10 ea	
☐ Phenergen (suppository 50mg ea)	$12.74 ea		☐ Lidocaine	$21 ea	
☐ Suprax (Cefixime) (tabs/ea)	$11.25 ea		☐ Tetanus	$21 ea	
☐ Cipro (Ciprofloxin) (tabs/ea)	$8.00 ea		☐ Other (Specify) _____		
☐ Doxycycline (tabs/ea)	$2.84 ea				
☐ Hepatitis B vaccine	$21.00 ea				

Total Amount Billed

$_____

Please Remit Payment To:

Fed Tax#_____

Health Care Provider must attach a copy of **the Medical Examination Release Form (located in the SLED approved protocol kit) to this Protocol Billing Statement** for payment and forward to:

State Office of Victim Assistance
1205 Pendleton Street
Edgar A. Brown Building, Room 401
Columbia, SC 29201

SOVA | Medical Examination Release Form

PSD003 07/14

In the matter of:

Patient	Name of Health Care Provider
Social Security Number	Federal Tax Number
Address	Address
City State Zip	City State Zip

In accordance with South Carolina Victims and Witnesses Bill of Rights, signed into law on June 22, 1984, I hereby voluntarily consent and authorize the South Carolina State Office of Victim Assistance (SOVA) and its authorized agents to receive my medical records. I also authorize SOVA to pay such medical expenses allowed by law to Health Care Providers for routine medical tests and examinations for evidentiary purposes as prescribed by South Carolina Law Enforcement Division (SLED)/South Carolina Hospital Association sexual assault protocol kit.

Dated this _____ day of _____, 20_____, at

_____, South Carolina.

Signature of Patient/Guardian/Responsible Adult	Health Care Official's Signature (SANE/MD)
Print Name of Law Enforcement Officer	Signature of Law Enforcement Officer

Name of Law Enforcement Agency (Do not abbreviate) – For anonymous reporting: write in "Anonymous"

Incident Location (County and State) **Date of Crime**

For consideration of the payment, the following questions must be answered:
Was the incident location in a federal, state, county or municipal jail, prison or other correctional facility? __Yes __No

Was the patient confined in any federal, state, county, or municipal jail, prison or other correctional facility at the time of service? ___Yes ___No

If you answered no to both questions, health care providers must attach a copy of **SOVA Sexual Assault Protocol (SAP) Billing Statement (located in the SLED approved protocol kit) to this Medical Examination Release Form** for payment and forward to:

STATE OFFICE OF VICTIM ASSISTANCE
1205 Pendleton Street, Rm. 401
Columbia, South Carolina 29201
Phone: 803.734.1900

SOVA: Forensic Interview Report

07/14

State Office of Victim Assistance 1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC 29201 803.734.1900

Today's Date _____

Victim's Legal Name:_____

Age:_____ Date of Birth:_____ Gender_____ Race_____

Was the forensic interview done as a part of an investigation of an alleged crime? Yes _____ No_____

Type of Allegation:
- Physical Assault_____
- Sexual Assault_____

Outcome of Forensic Interview
- No disclosure _____
- Disclosure of assault _____
- Problematic disclosure _____
- Recantation of prior disclosure _____
- Forensic assessment not completed _____reason?_____

_____

Professional Opinion: Was allegation a result of a crime? Yes_____ No_____

Location of Crime: _____
City/County State

Basis of Professional Opinion: (What happened; where; who; when, if possible)

Name/Title of Interviewer _____
Interviewer License # _____Type_____
Or Supervisor name and license #_____
Date/Place of Interview _____
Law Enforcement Jurisdiction_____

The Children's Advocacy Center must attach a copy of the Forensic Interview Billing Statement, the Forensic Interview Release Form, and a law enforcement incident/supplemental report to this Forensic Interview Report for payment and forward to:

State Office of Victim Assistance
1205 Pendleton Street
Edgar A. Brown Building, Room 401
Columbia, South Carolina 29201

State of South Carolina
State Office of Victim Assistance
Forensic Interview Release Form

In the matter of:

Patient	Name of Forensic Interviewer
Social Security Number	Name of Children's Advocacy Center
Address	Address
City State Zip	City State Zip

In accordance with South Carolina Victims and Witnesses Bill of Rights, signed into law on June 22, 1984, I hereby voluntarily consent and authorize the South Carolina State Office of Victim Assistance and its authorized agents to receive my interview records and to pay directly such expenses allowed by law to the Children's Advocacy Center for the forensic interview conducted for evidentiary purposes as prescribed by South Carolina State Office of Victim Assistance.

Dated this _____ day of _____ , 20_____, at

Signature of Patient/Guardian/Responsible Adult	Forensic Interviewer's Signature

- Did Law Enforcement contact you to request this exam ____Yes ___No
- If you answered No, SOVA will not cover the cost of this exam. Note that SOVA only cover the cost when Law Enforcement initiates the contact.
- SOVA does not cover the cost of the exam if another Government Agency has legal custody of the child.
- If you answered Yes, and the child is not in the legal custody of another Government Agency, please complete the following information:

Name of Law Enforcement Officer requesting the exam | Date of the request | Contact information

Signature of Law Enforcement Officer | Name of Law Enforcement Agency

The Children's Advocacy Center must attach a copy of the Forensic Interview Billing Statement, the Forensic Interview Report, and a law enforcement incident/supplemental report to this Forensic Interview Release Form for payment and forward to:

STATE OFFICE OF VICTIM ASSISTANCE
1205 Pendleton Street
Edgar A. Brown Building, Room 401
Columbia, South Carolina 29201
Phone: 803.734.1900

SOVA: Forensic Interview Billing Statement

07/14

State Office of Victim Assistance 1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC 29201 803.734.1900

Invoice Date: _____ Invoice # _____

Date of Service: _____

Victim's Legal Name: _____

Date of Birth: _____ SS# (Last 5 Digits): _____ Crime Date: _____

Was this interview requested by Law Enforcement? Yes_____ No_____

Remit payment to:

Tax ID Number: Telephone Number:

Total Charge $175.00

Name/Title of Interviewer _____

The Children's Advocacy Center must attach a copy of the Forensic Interview Report, the Forensic Interview Release Form, and a law enforcement incident/supplemental report to this Forensic Interview billing statement for payment and forward to:

State Office of Victim Assistance
1205 Pendleton Street
Edgar A. Brown Building, Room 401
Columbia, South Carolina 29201

SOVA
South Carolina State Office of Victim Assistance
An Office of the Governor

South Carolina Children's Advocacy Medical Response System

Child Maltreatment Protocol Billing Statement

Child's Name (last, first, MI) :			**SSN**
Date of Birth (mm/dd/yy):	**Age:**	**Gender** ☐ Male	☐ Female
Race ☐ American Indian/Alaska Native	☐ Black/African American	☐ Pacific Islander	
☐ Asian	☐ Multiracial	☐ White/Caucasian	
☐ Biracial	☐ Other: *Specify*		
Ethnicity ☐ Hispanic	☐ Non-Hispanic	☐ Other: *Specify*	
Account Number:		**Date of Crime (mm/dd/yy):**	
Facility Name:		**Telephone Number:** ( ) -	
Place of Incident:	**County:**	**State:**	
Law Enforcement Agency (do not abbreviate):		**Case Number:**	

Evaluation For (check all that apply)

☐ Drug Endangered Child	☐ Pediatric Condition Falsification	☐ Threat of Harm
☐ Failure to Thrive	☐ Physical Abuse	☐ Physical Abuse
☐ Neglect	☐ Sexual Abuse	☐ Sexual Abuse
Specify:	☐ Other: *Specify*	

Other Miscellaneous Injuries

☐ Burns	☐ Fractures	☐ Lacerations/Wounds
☐ Contusions/Bruises	☐ Head/Scalp Injuries	☐ Scars
☐ Other: *Specify*		

Healthcare Provider Signature:	**Date:**

Healthcare provider and/or facility **must attach a copy of the Law Enforcement Incident Report** and **Authorization and Release Form** to this billing statement for payment and forward to:

State Office of Victim Assistance
1205 Pendleton Street
Edgar Brown Building, Room 401
Columbia, SC 29201

SOVA
South Carolina State Office of Victim Assistance
An Office of the Governor

South Carolina Children's Advocacy Medical Response System

Child Maltreatment Protocol Billing Statement Supplement

Child's Name (last, first, MI) :

DOB (mm/dd/yy): | **Date of Evaluation (mm/dd/yy):**

Medical Services		Procedures	Miscellaneous Fees
☐ Healthcare Provider Fee ($105) ☐ Clinic Fee ($50)	☐ Emergency Room Fee ($75)	☐ Colposcopy Fee ($90)	☐ Supplies ($12)

Laboratory Services

☐ Gonorrhea Culture	☐ GramStain	☐ CBC ($35)
☐ Oral ($12)	☐ Urethral ($10)	☐ Platelet Count ($20)
☐ Rectal ($12)	☐ Vaginal ($10)	☐ SMA - Basic Metabolic Panel ($27)
☐ Vaginal ($12)	☐ RPR, VDRL, Syphilis ($10)	☐ Liver Function Test ($59)
☐ Chlamydia Culture	☐ Hepatitis B ($40)	☐ Amylase ($22)
☐ Rectal ($35)	☐ HIV by Elisa ($20)	☐ PT & aPTT ($40)
☐ Vaginal ($35)	☐ B-HCG, Blood ($25)	☐ Fibrinogen ($37.50)
☐ NAAT ($50)		☐ von Willebrand Antigen ($126)
☐ Trichomonas Vaginalis Culture ($35)	☐ Urinalysis ($18)	☐ Ristocetin Cofactor ($56)
☐ Herpes Simplex Culture ($20)	☐ Urine Culture & Sensitivity ($20)	
☐ Vaginal Culture ($20)	☐ Urine Pregnancy Test ($20)	☐ Blood Drawing Fee ($5)
☐ Wet Prep/ KOH Prep ($10)		
	☐ Urine Drug Screen ($50)	

Radiographs/ Imaging Studies

☐ Skeletal Survey Complete ($140)	☐ Hand - Minimum 3 Views ($52)	☐ Spine Entire AP LAT ($275)	
	☐ Pelvis AP ($75)	☐ Lumbar Spine ($95)	
☐ Skull - 4 Views ($80)	☐ Pelvis & Hips - Infant ($90)	☐ Thoracic Spine ($90)	
☐ Chest PA & Lateral ($29)	☐ Femur ($25)		
☐ Humerus ($55)	☐ Tibia Lower Leg ($25)	☐ CAT Scan ($500) Head	☐ CAT Scan ($500) Abdomen
☐ Forearm ($25)	☐ Cervical Spine ($90)		
		Total Amount Billed $	

Please remit payment to:

Tax ID Number:

Healthcare provider and/or facility must attach a copy of the **Law Enforcement Incident Report/Supplemental Report**, **Authorization and Release Form**, along with pages 1 and 2 of this **Child Maltreatment Protocol Billing Statement** for payment.

Child Maltreatment Protocol

AUTHORIZATION AND RELEASE

I authorize _____ to release medical information
Facility Name

related to this incident to:

- ☐ State Office of Victim Assistance (SOVA)
- ☐ Department of Social Services
- ☐ Law Enforcement
- ☐ Solicitor
- ☐ Guardian ad Litem
- ☐ SC Children's Advocacy Medical Response System

and hold harmless this facility and its staff, from any and all liability and claims of injury which may in any manner result from the release of such information.

I also authorize the release of medical information to:

- ☐ Private Physician
- ☐ Mental Healthcare Provider
- ☐ Other *Specify* _____

for the continuing diagnosis and treatment of this child.

I request and authorize the State Office of Victim's Assistance (SOVA) to assign the payment for medical services provided on this child's behalf to:

Facility Name _____

Address _____

City _____ State _____ Zip Code _____

I permit a copy of this authorization to be used. I understand that I have the right to withdraw this authorization at any time by notifying this facility in writing. I understand that the withdrawal is not effective for any actions taken prior to this withdrawal. Without a written notice to withdraw this authorization, it will expire 1 year from the date the medical service is provided.

Child's Name: _____ Date of Birth: _____ SSN:(Last 5 Digits) : _____

Address: _____

Contact Phone Number _____

By signing, I consent to the authorization and release of medical information of the named child as described above.

_____ _____ Date: _____
Signature of Parent/Legal Representative Printed Name

_____ _____ Date: _____
Signature of Parent/Legal Representative Printed Name

_____ _____ Date: _____
Signature of Witness Printed Name